Dear Applicant:

Enclosed you will find the forms necessary for you to apply for licensure as a speech-language pathologist/audiologist (SLP/A). It is strongly suggested that you read the regulations prior to filling out the application, and then examine the directions entitled **"STEPS TO LICENSURE"** to see which forms are appropriate for you. Please note the following:

(a) Applications not completed in their entirety will be returned, minus the applicable fees, which are non-refundable.
(b) The photograph must be a "passport-style photo."
(c) The practice history must be current and complete (form enclosed).
(d) The names on the application and the licensure requirements must be the same or a copy of the legal document(s) effecting the name change(s) must be included with your application. The name on the driver's license or U.S. Social Security Card must be the same as the name on the application. We will not accept nicknames, abbreviations, or alterations.
(e) The home address on the application is considered the address of record. Written notice signed by the applicant is required for any address change.
(f) All checks/money orders for fees are to be made payable to the Mississippi State Department of Health.
(g) Our overnight mail address (see "**OVERNIGHT MAIL**") is as follows:

Mississippi State Department of Health
Professional Licensure - SLP/A
570 East Woodrow Wilson Blvd.
Jackson, MS 39216

Please be advised that it is illegal to practice or represent oneself as a speech-language pathologist or audiologist in Mississippi unless currently licensed in accordance with the provisions of these regulations or specifically exempted by state statute. It should be noted that a hearing aid specialist license is required to dispense and fit hearing aids.

If you have any questions regarding the above, please contact the licensure office.

Sincerely,

Stephanie Boyette
HPS, Sr.

STEPS FOR LICENSURE

Enclosed is a licensure packet for speech-language pathologists and/or audiologists. Two types of licensure are currently issued in Mississippi. The requirements for each are as follows:

I. Regular

1. Completed and notarized application;
2. Fees ($200.00) - $100.00 Application fee and $100.00 Licensure fee
3. Verification of all SLP/A licensure/registration, current or not current, reported directly to this office from the licensing authority (with seal);
4. Certified transcript indicating that a masters degree or higher was awarded in the area of Speech-Language Pathology/Audiology reported directly to this office from the institution awarding it (with seal);
5.* Proof of satisfactory completion of the Clinical Fellowship Year (CFY) reported directly to this office from ASHA or of satisfactory Supervised Professional Employment Program (SPEP) completion; and
6.* National Exam in Speech-Language Pathology or Audiology Score (minimum passing score: 600).

*NOTE: An applicant holding the ASHA CCC may submit a copy of his/her current ASHA Certified Member Card in lieu of items 5 and 6 above.

II. Temporary (Supervised Professional Employment Plan (SPEP) participants only):

1. Completed, notarized application;
2. Fees ($175.00) - $100.00 Application fee; $75.00 Licensure fee
3. Certified transcript indicating a Masters Degree or higher was awarded in the area of Speech-Language Pathology/Audiology reported directly to this office from the institution;
4. Original SPEP Agreement form. The supervisor must have a current, regular license to practice in Mississippi.
5. Verification of all SLP/A licensure/registration, current or not current, reported directly to this office by the licensing authority (with seal).

NOTES: (1)An applicant's National Exam in Speech-Language Pathology or Audiology score must be submitted prior to a license being upgraded to regular (minimum passing score: 600). (2)An SPEP Report must be filed upon the completion of the SPEP along with a $25.00 fee.

The application review process begins once all licensure requirements are on file and generally takes 7-10 week days. Requirements must be satisfactory to this office before a license of any kind will be issued.

OVERNIGHT MAIL

Overnight mail packages containing official, verification documents must be shipped directly to the Department of Health from the institution or agency office. The licensure requirement should be sealed in an official envelope of the reporting office within the overnight package. Official, verification documents mailed through the applicant or a third party will not be accepted for licensure purposes.

Enclosures:

1. Licensure application
2. Verification of Licensure form
3. Practice History form
4. *Regulations Governing Licensure of Speech-Language Pathologists and Audiologists*

PRACTICE HISTORY

Instructions: Please list the facility, home health agency, etc., its location (city & state), and the dates that you practiced at that facility in chronological order beginning with your last practice site. A resume' may be attached if the information needed to complete this history is on the resume'. This sheet may be copied if additional space is needed.

FACILITY	LOCATION	DATES
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

MS State Department of Health
Professional Licensure
P.O. Box 1700
Jackson MS 39215-1700

Supervised Professional Employment Plan (SPEP) Agreement
Speech Language Pathology/Audiology

I. Temporary Licensee/SPEP Participant:

Name: _____

Address: _____
Street City State Zip Code

Telephone Number: ( ) _____ Social Security Number: _____

II. Supervisor:

Name: _____

Address: _____
Street City State Zip Code

Telephone Number: ( ) _____ Social Security Number: _____

License number: _____

ASHA Certification Area: ❒SLP ❒ AUD

III. SPEP Setting:

Facility Name: _____

Address: _____
Street City State Zip Code

Telephone Number: ( )_____

Beginning date of SPEP _____/_____/_____ Ending date of SPEP _____/_____/_____

IV. SPEP Experience:

A. Indicate the length of the SPEP experience and number of hours per week below:

- ❒ 36 weeks of full time professional employment of at least 30 hours per week.
- ❒ 48 weeks of full time professional employment of at least 25 hours per week
- ❒ 60 weeks of full time professional employment of at least 20 hours per week
- ❒ 72 weeks of full time professional employment of at least 15 hours per week

At least 80% of the SPEP week will be spent in direct client contact (assessment/diagnosis/evaluation, screening, habilitation/rehabilitation) and activities related to client management.

❒ yes ❒ no

B. Professional clinical employment responsibilities:
(List approximate number of hours a week in each activity.)

Activity	Hours per week
Assessment/ diagnosis/evaluation	_____
Screening	_____
Treatment (direct and indirect services)	_____
Activities related to client management (report writing, family/client consultation/counseling, etc.)	_____
Inservice training	_____

V. SPEP Supervision

A. ❒ There will be at least 36 supervisory activities during the entire SPEP, including 18 hours of on-site observation and 18 other monitoring activities. SPEP supervision will be divided equally among three segments (1/3 length of SPEP). There will be at least 6 hours of on-site observation and at least 6 other monitoring activities during each segment of the SPEP. All supervisory activities must be documented and filed with the SPEP Report.

B. Supervision

Methods	Times per mo.	Length-hrs.	Activity (See list under sec. IV(B) of this form)
1. On-site observations	_____	_____	_____
2. Remote observation (audio-video-tape-telephone)	_____	_____	_____
3. Conferences (Telephone-corres.)	_____	_____	_____
4. Review of records (A) Therapy Plans (B) Diagnostic rpts.	_____	_____	_____
5. Staff meetings	_____	_____	_____
6. Case meetings	_____	_____	_____
7. Other	_____	_____	_____

VI. Rules for the SPEP

(1) An SPEP participant must be issued a temporary license prior to beginning the SPEP.

(2) A temporary licensee may only practice in the SPEP setting.

(3) The SPEP setting must be designed to evaluate, habilitate, or rehabilitate individuals with speech, language and hearing difficulties.

(4) The SPEP setting must allow the temporary licensee to complete the SPEP as planned. This is the temporary licensee's responsibility.

(5) Direct patient contact, consultations, record keeping, or other duties relevant to a program of clinical works are the only activities to be included in an SPEP.

(6) A temporary licensee must submit a new SPEP agreement prior to beginning the new SPEP if there is a change in the setting, supervisor, or number of hours worked per week. An SPEP report must be filed by the licensee who is terminating supervision or changing the SPEP. (see #10)

(7) The supervisor is responsible for all treatment for a patient by the SPEP participant.

(8) The SPEP must be completed at settings in the State of Mississippi.

(9) The SPEP supervisor is required to report any unacceptable practices to the Branch within five (5) calendar days. A plan detailing corrective measures must accompany any such report.

(10) The SPEP supervisor has ten (10) calendar days from the end of the SPEP in which to file the SPEP Report with the Branch for review. The Branch will take appropriate action regarding licensure following the review. A temporary licensee receiving an unsatisfactory SPEP report will be given an opportunity to challenge the report.

VII. Supervisor's Agreement:

I agree to conduct one formal evaluation during each segment of the SPEP. I have read and discussed this agreement with the applicant and have agreed to supervise the applicant as specified above. I have read and understand *The Regulations Governing Licensure of Speech Langauge Pathologists and Audiologists*. I agree to complete and submit an SPEP Report form to the Mississippi Department of Health, Professional Licensure Branch, within 10 days of the completion of the SPEP experience. I will fulfill this responsibility even if I am unable to approve the SPEP. Futhermore, I verify that my license is current and will be maintained during the SPEP.

The SPEP is being used to satisfy the requirements of a Clinical Fellowship Year (CFY) for certification by ASHA.

❒ yes ❒ no

_____

signature of supervisor date

VIII. Temporary License Applicant's Agreement:

I have read, discussed, and agreed with the supervisor on all sections listed above. I have verified that my supervisor holds a current license in the area in which I am seeking licensure. I have read and understand *The Regulations Governing Licensure of Speech Language Pathologists and Audiologists.*

The SPEP is being used to satisfy the requirements of a Clinical Fellowship Year (CFY) for certification by ASHA.

❒ yes ❒ no

_____

signature of applicant date

Note: Please submit the original copy to Professional Licensure and keep a copy for your records.

Speech-Language Pathologist
and/or Audiologist

Application for License

(Please type or print in ink)

MISSISSIPPI
STATE DEPARTMENT OF HEALTH

Office Use

Check No._____

Amount $_____

Date ____/_____/____

License Type

Speech-Language Pathologist ☐
Audiologist ☐

Temporary ☐ *(CFY or SPEP participants only)*

Personal

Name: _____
(Last) (First) (Middle)

Home Address: _____
(Street)

_____ Telephone Number (____)_____
(City) (State) (Zip Code) (County)

U.S. Social Security No. ☐☐☐ - ☐☐ - ☐☐☐☐ Date of Birth: ☐☐ - ☐☐ - ☐☐

Race:_____ Sex: Male ☐ Female ☐ U.S. Citizen: No ☐ Yes ☐ Legal Alien: No ☐ Yes ☐ Visa Type & No.:_____

Professional

Employer: _____

Business Address: _____

_____ Telephone Number (____)_____
(City) (State) (Zip Code) (County)

Practice Type

Insert # _____

1. Patient Care
2. Administration
3. Teaching
4. Research
5. Other Activity
6. Not Active in SLP/A

Practice Setting

Insert Primary # _____ Secondary #_____

1. >100 Bed Hospital
2. <100 Bed Hospital
3. Nursing Home
4. Home Health
5. Physician's Office
6. School
7. Private Practice
8. College/University
9. Outpatient Facility
10. Other

Education

Certified transcript must be reported directly from the institution.

School _____
(Name) (City) (State) (Country)

Type of Degree _____ Date_____

Licensure

Have you ever been licensed or registered in any state, territory or country? No ☐ Yes ☐ If yes, list all licenses (current/not current) including Mississippi. ***All licenses must be verified by the licensing authority - with board seal. (See Verification of Licensure Form.)***

1. _____ 4. _____ 7. _____ 10. _____
2. _____ 5. _____ 8. _____ 11. _____
3. _____ 6. _____ 9. _____ 12. _____

Licensure *(continued)*

Have you ever had a license or permit encumbered in any way, i.e., revoked, suspended, rejected, placed on probation, etc? No ☐ Yes ☐

Are there any criminal or civil suits pending against you? If yes, attach a copy of the complaint. No ☐ Yes ☐

Have you ever been convicted of any violations of law (except minor traffic violations)? No ☐ Yes ☐

Examination

(Current CCC-A/CCC-SLP) Omit this section and attach copy of current ASHA Certified Member Card.
Have you ever taken the NTE? No ☐ Yes ☐ If yes, please attach score report.

Occupational Status Attach completed Practice History form

Supervision Temporary license applicants only. Attach CFY Registration Agreement or SPEP.

Fees

Fees enclosed: ___$100.00___ Application $100.00

_____ Regular Licensure $100.00

_____ Temporary License $75.00

_____ Total (non-refundable)

Make check or money order payable to:
Mississippi State Department of Health

I, the undersigned, so solemnly swear or affirm that I am the above applicant. I have read the above application and all statements contained therein or accompanying this application are true to the best of my knowledge and belief. I have also read and understand the Regulations Governing Licensure of Speech-Language Pathologist and Audiologists and affirm that all conditions for Licensure have been met and will be maintained.

_____
(Applicant's Signature)

Complete form, enclose fee and mail to:
Mississippi State Department of Health
Professional Licensure: SLP/A
P. O. Box 1700
Jackson, Mississippi 39215-1700

Attach Copy of Driver's License or U.S. Social Security Card

Attach Photo

Subscribed and sworn to before me this _____ day

of _____, 19 _____.

My commission expires _____.

_____
(Notary Public)

Speech-Language Pathologist/Audiologist

Verification of License in Another State

To be Completed by Applicant *(Please print or type)* Social Security No.:_____-_____-_____

Name:_____

Licensing Authority:_____ Number:_____ Date Issued: _____
(State, Territory, or Country)

_____
(Applicant Signature)

To be Completed by Secretary of Licensing Board

Licensee's Name: _____

License Type (SLP/A): _____

License Number: _____

Date Issued: _____

Expiration Date: _____

Licensed By: State Exam:_____

Reciprocity with: _____

ASHA CCC Credential: _____

Has license ever been disciplined? ☐ No ☐ Yes *(if yes, please attach findings and disposition.)*

Remarks: _____

_____

_____

Licensing Board must return to:
Mississippi State Department of Health
Professional Licensure: SLP/A
Post Office Box 1700
Jackson, Mississippi 39215-1700

_____
(Authorized Signature)

This document must show Seal of licensing agency.

Seal

MS State Department of Health
Professional Licensure
P.O. Box 1700
Jackson MS 39215-1700

Supervised Professional Employment Plan (SPEP) Report
Speech Language Pathology/Audiology

I. Temporary Licensee/SPEP Participant:

Name: _____

Address: _____
Street City State Zip Code

Telephone Number: ( ) _____ Social Security Number: _____

License Number: _____

II. Supervisor:

Name: _____

Address: _____
Street City State Zip Code

Telephone Number: ( ) _____ Social Security Number:_____

License Number: _____

ASHA Certification Area: ' SLP ' Audiology

III. SPEP Setting:

Facility Name:_____

Address: _____
Street City State Zip Code

Telephone Number: ( )_____

Beginning date of SPEP _____/_____/_____ Ending date of SPEP _____/_____/_____

How many weeks of the SPEP does this report cover? _____weeks
How many hours per week were spent in:

Speech-Language Pathology?_____Hrs. Audiology_____Hrs.

IV. Supervisory Activities:

There were 36 supervisory activities during the SPEP, including 18 hours of on-site observations in direct client contact and 18 other monitoring activities. _____Yes _____No

SPEP supervision was divided equally among three segments including 6 hours of on-site observation and at least 6 other monitoring activities during each segment of the SPEP. _____Yes _____No

Direct clinical activities: At least 80% of the SPEP weekly activities must be in direct clinical activities related to the management process of individuals who exhibit communication difficulties. Specify the number of hours per week spent in each of the following activities.

Activity	Hours per week
Assessment/ diagnosis/evaluation	_____
Screening	_____
Treatment (direct and indirect services)	_____
Activities related to client management (report writing, family/client consultation/counseling, etc.)	_____
Inservice training	_____
TOTAL	_____

Complete the following chart indicating the distribution of on-site observation hours and other monitoring activities completed during each segment of the SPEP. Include only activities supervised by the individual identified as the supervisor in this report. Complete a separate SPEP Report for activities supervised by different individuals.

Weeks of SPEP	***Number of On-Site Hours***	***Number of Other Monitoring Activities***
Weeks 1-4		
Weeks 5-8		
Weeks 9-12		
Weeks 13-16		
Weeks 17-20		
Weeks 21-24		
Weeks 25-28		
Weeks 29-32		
Weeks 33-36		
Weeks 37-40		
Weeks 41-44		
Weeks 45-48		
Weeks 49-52		
Weeks 53-56		
Weeks 57-60		
Weeks 61-64		
Weeks 65-68		
Weeks 69-72		
TOTALS		

Documentation of Skills:

While under my supervision during the SPEP, the temporary licensee exhibited a satisfactory level of competency for the skills listed below. A satisfactory level of competency means that, in most situations, the temporary licensee independently, accurately, and consistently performed the skills. The temporary licensee appropriately sought my supervision when needed outside of the normal supervisory activities.

1. Implements screening procedures.
2. Collects case history information and integrates information from client, family, care givers, significant others, and other professionals.
3. Selects and implements evaluation procedures (nonstandardized tests, behavioral observations, and standardized tests.
4. Adapts interviewing and testing procedures to meet individual client needs.
5. Interprets and integrates test results and behavioral observations, synthesizes information gained from all sources, develops diagnostic impressions, and makes recommendations.
6. Develops and implements specific, reasonable, and necessary treatment plans.
7. Selects/develops and implements intervention strategies for treatment of communication and related disorders.
8. Selects/develops and uses intervention materials and instrumentation for treatment of communication and related disorders.
9. Plans and implements a program of periodic monitoring of the client's communicative functioning through the use of appropriate data collection systems. Interprets and uses data to modify treatment plans, strategies, materials, and/or instrumentation to meet the needs of the client.
10. Adapts intervention procedures, strategies, materials, and instrumentation to meet individual client needs.
11. Schedules and prioritizes direct and indirect service activities, maintains client records, and documents professional contacts and clinical reports in a timely manner.
12. Complies with program administrative and other regulatory policies such as required due process documentation, reports, service statistics, and budget requests.
13. Demonstrates communication skills (including listening, speaking, nonverbal communication, and writing) that take into consideration the communication needs as well as the cultural values of the client, the family, care givers, significant others, and other professionals.
14. Identifies and refers clients for related services including audiological, educational, medical, psychological, social, and vocational, as appropriate.
15. Collaborates with other professionals in matters relevant to case management.
16. Provides counseling and supportive guidance regarding the client's communication disorder to client, family, care givers, and significant others.

Any unsatisfactory practice was reported to the MSDH as required and has been sufficiently corrected. I have discussed this report with the temporary licensee. I verify that my license in Mississippi was current throughout the SPEP.

Was the SPEP used to satisfy the requirements of a Clinical Fellowship Year (CFY) for certification by ASHA?
_____Yes _____No

_____

signature of supervisor/license number date

I have read and discussed this report with my SPEP supervisor. I verified that my supervisor held current licensure in Mississippi throughout the entire SPEP. I agree/do not agree with the findings of this report.

_____

signature of applicant/license number date

Note: The supervisor should submit the original copy to Professional Licensure and keep a copy for his/her records. A check for $25.00 made payable to the MS State Department of Health (MSDH) should be filed by the temporary licensee for a regular license.